

Essence of Eve Day Med Spa

Client Profile Information

First Name: _____ Middle _____
Initial: _____ Last: _____ Date ____/____/____

U. S. Postal Address

City: _____

State: _____ ZIP: _____

Email Address:

_____@_____

This email address is used to email you reminders of your appointment.

Would you like to receive our email newsletters:

_____ Yes _____ Prefer Not

Home Phone # _____ / _____ / _____

Office Phone # _____ / _____ / _____

Cell Phone # _____ / _____ / _____

Personal Information

Name of Emergency Contact:

Cell Phone # _____ Other Phone # _____

Relation: _____ Your Birthday! ____ / ____ / ____

Who referred you? _____

We may ask you to complete one of these periodically in the event we need to update our records!

Completed By All Clients! Thanks for understanding!

Waiver Of Liability & Your Signature!

We appreciate updated information upon your next visit in order to insure your well being!

Waiver of Liability: I understand that all service providers are licensed as required and that they are not intended to prescribe medical treatment or pharmaceuticals, nor do they perform spinal manipulations. It has been made very clear to me that these services are not a substitute for medical examinations and/or for diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.

Because all therapists must be aware of existing physical conditions as well as any medications that I am on, I have stated all my known medical limitations and medications and take it upon myself to keep the therapists updated on my physical health.

Client Signature

Date

How did you hear about Essence of Eve? _____

Check only those you have had or you currently have:

HIV/Aids Migraine Headaches Insomnia High Blood Pressure
 Herniated Disc Cancer Arthritis Varicose Veins
 Neck/Back Pain Diabetes Sciatica Ezcema
 Athletes Foot Fungus Thrombophlebitis Heart Problems Psoriasis

Have you been diagnosed with any form of Hepatitis or any blood-born disease

Currently Use Tobacco products

Claustrophobic

How much water do you consume daily approximately _____

On Blood thinners (If checked please describe) _____

Currently am Pregnant or plan on being pregnant
(If checked please denote what month) _____

Currently a Nursing Mother

Allergies (Food, Medication, Animal, Seasonal – please denote) _____

Have you within the past 6 months had surgery (If checked please describe) _____

Surgery Date: _____

State Concerns You may have pertaining to your health: _____

Do you have aversions to certain smells and/or fragrances? Please specifically, eucalyptus, lavender, rose, etc. _____

For Massage Clients Only!

What type of massage pressure do you prefer (light, medium, deep) _____

Please list any injuries or special concerns you may have pertaining to your body for massage

For Facial Clients Only!

Check items that pertain to you.

Hormone Imbalance Skin Disorders/Diseases Metal Implants or Pacemaker

Check items that you have had reactions to.

Cosmetics Fruit Vegetables Fragrances

Aspirin Herbs Essential Oils Sun screens

If you checked any of the above please describe: _____

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Use sun screen SPF # _____

Participate in any outdoor activities

Tendency for redness

Take stimulants

Have sinus problems

Wear contact lense

When masqueing during facial services I prefer to be alone.

I prefer light medium deep massage pressure.

Have you seen a Dermatologist in the past year? _____

If yes, list reason for visit _____

Are you presently under a physician's care for any reason? _____

What medications do you take on a regular basis? _____

Are you using or have you ever used any medications for acne? _____

Have you ever had Herpes (cold sores)? _____

Have you ever been treated for Herpes (cold sores)? _____

Chemical Peels – If checked how many _____? When was last peel? _____

Use/Used Retin A – If checked how long? _____ When? _____

Use/Used Accutane – If checked how long _____ when? _____

List skin care products you use daily. _____

Please check any skin conditions you may want to improve.

____Hyperpigmentation(Brown Spots) ____Acne ____Acne Scarring
____Sun Damage ____Enlarged Pores ____Fine Lines & Wrinkles ____Age Spots
____Surgical Scars ____Flakiness/Dryness ____Breakouts

EofEDayMedSpa/Client Profile/ 2008 January